DEPARTMENT OF BEHAVIORAL HEALTH SERVICES (DBHS)

CARE Campus

Supportive Aftercare Community (SAC)/Mariposa

Program Application

(PLEASE PRINT CLEARLY)

Date Received:_____

Staff Complete Only

Applying for SAC ☐ Mariposa Program ☐

Last Name:	**MI:**	**First Name:**
Date:	DOB: / /	Age:
Gender Identity: Male ___Female___ Transgender___ Genderqueer/Gender non-conforming___ Different identity (please state): _____		
Sexual Orientation:	SSN:	
Race/Ethnicity:	Currently Employed: Y N How long: Employer:	
Marital Status:	Are you a Veteran: Y N Branch: Discharge Date: Type of Discharge:	
Briefly describe current living arrangements: (Relatives, Homeless, Shelter, Renting) _____		
Primary or Preferred Language:	Religious Preference (If any):	
Annual Income Level: (Please Circle) $0 $1-9,999 10,000-19,999 20,000+ What income do you receive? (SSI, SSDI, VA Disability, Employment, etc.)	Highest Level of Education: _____ (Completed) Have you ever applied for HSD Benefits? Y N Are you eligible for food stamps? Y N	
Have you ever participated in a Bernalillo County Dept. of Behavioral Health Program before? Y N (CIRCLE) CARE Campus DETOX ATP in MDC SUPPORTIVE AFTERCARE COMMUNITY When:		
Do you have pending charges? Y N What charges: Do you have a pending court date? Y N If Yes, When:	Are you currently on Probation or Parole? Y N Probation Officer Contact Info: Parole Officer Contact Info: Do you have any active restraining orders? Y N If yes, with whom and when does it expire?	
Emergency Phone Contact: (Name):	Phone Number:	

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What is your relationship to contact person?

If you do not answer or return the phone call from your contact number listed above, can we contact your emergency contact person to follow up with the status of your application to the program?:

Yes No

Primary Care Doctor: Phone Number: Address:

Have you ever been diagnosed with a mental health problem(s)? Y N

List Diagnosis:

When & where given Diagnosis: Month / year agency

Are you current receiving disability for a mental health problem? Y N

Are you currently seeing a Psychiatrist/Psychologist/Therapist? Y N

If yes, Name: Contact Number:

Current Medications taken for mental health problems:

Currently Pregnant: Y N Due Date: _____

How many children do you have under the age of 18? _____ How many have lived with you in the last 12 months? _____

Child Name Male/Female Age Caretaker If living with you, who will take care of children while in program

1. _____
2. _____
3. _____

If additional, just list names and age:

Do you have any current medical problems (list)?

Are you currently receiving disability for a medical problem? Y N

List need for any special accommodations (Ex. Wheelchair, Hearing Impairment needs, Visual impairment needs) :

What is your usual hospital for medical treatment?

Name of primary care doctor (if applicable) : Phone Number:

Any current medications for medical problems?

HAVE YOU EVER BEEN …

Hepatitis Tested Y N When: Result: Type:

HIV Tested: Y N When: Result:

TB Tested: Y N When: Result:

Any known allergies?

Do you currently have Health Insurance? Y N

Ins. Company: Policy #: Contact Number:

Primary Drug (s) of use:

List prior treatment(s) for Substance abuse:

	Agency Name	Type of treatment (rehab / detox)	Month / Year attended	How long were you clean/sober after treatment?
1.				
2.				
3.				

Have you ever been arrested for Domestic Violence? Y N How many times? _____

Have you ever been arrested for DWI? Y N How many times: _____ What Year(s): _____

Other Arrests in last 12 months (Please List) _____

Have you ever been convicted of a felony? Y N If yes, charge and year _____

_____

Any additional add here:

How do you generally handle your anger?

What would you consider to be your triggers to use to use?

What has worked in the past to keep you from using drugs or alcohol?

Did your parents use any substance(s) while you were growing up? Y N

How many siblings in your immediate family?

Do you have a history of trauma? Experienced___ Witnessed____

Were you ever abused? Y N

In what way (circle all that apply): Emotional Physical Sexual Neglect

Do you need any assistive technology or accommodations to support a disability?_____

Please provided a detailed personal statement in your own words about why you feel recovery is possible in your life at this time and how you see SAC/Mapriposa helping you in your recovery journey:

Signature

Applicant: _____ Signature: _____
PRINTED NAME

Contact Phone Number: _____ Date: _____

SEND COMPLETED APPLICATION TO:

Fax: 505-462-9857 or **Email**: DBHSsacApplicationFax@bernco.gov

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